

00-19325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	September 24, 1986								
Richard DeSales Arnold														
3-SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male			White	July 24, 1924			62			YRS	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's					
10 CITY OR TOWN OF DEATH Mechanicsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) County Commissioner			12b KIND OF BUSINESS OR INDUSTRY Gover-					
13a STATE Md.			13b COUNTY St. Mary's			13c CITY OR TOWN Mechanicsville			13d INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE Box 101 (20659)		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME Cora Mae Buckler											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW11			16b SOCIAL SECURITY NO. WW11			16c INFORMANT Evelyn W. Arnold, Same as 13e.								
18 CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			20 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Renal cell cancer with 6 mos								
(b)			21 DUE TO, OR AS A CONSEQUENCE OF: Food metastasis and carcinoma of stomach as a second cancer											
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Liver metastasis with jaundice														
20a DATE OF OPERATION			20b CONDITION FOR WHICH OPERATION WAS PERFORMED			20c AUTOPSY?			20d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 22</u> , 19 <u>86</u> , to <u>Sept 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 22</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b SIGNATURE <u>J. Roy Guyther, M.D.</u>			22c DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 9-25-86					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Roy Guyther</u>			22e ADDRESS MECHANICSVILLE MD 20659											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 9/27/86			23c NAME OF CEMETERY OR CREMATORIAL Queen of Peace Cem.			23d LOCATION CITY OR TOWN Helen St. Mary's			COUNTY	STATE	
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.			25a DATE REC'D. BY REGISTRAR SEP 29 1986			25b REGISTRAR'S SIGNATURE <u>J. Roy Guyther</u>								

ESCI-00

00-18307

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1- STATE REGISTRAR										6	2	6	8	5	0
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR	
HILDA			DELORES		BALDWIN					<input checked="" type="checkbox"/>	9-13	19	86	1940 M	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			7c. DATE PRONOUNCED DEAD					
FEMALE	WHITE	JUNE 18, 1922	64 yrs.							9-14 1986					
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S								
10. CITY OR TOWN OF DEATH SCOTLAND			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SCOTLAND BEACH ROAD					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S		13c. CITY OR TOWN SCOTLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS BOX 35A, SCOTLAND BEACH RD.			20687			
14. FATHER'S NAME EDWARD			MIDDLE CHARLES		LAST SINGLETON		15. MOTHER'S MAIDEN NAME BERTHA			LAST BELLE			FLOWERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. UNK			17. INFORMANT RAYMOND BALDWIN, HAVRE de GRACE, MD. 21078									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Erosion of Pulmonary Venel by Cancer</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Edward T. Tarring</i> ADDRESS <i>Leonardtown, MD.</i> TITLE (SPECIFY) <i>Dpt</i> MEDICAL EXAMINER										DATE SIGNED <i>8/14/86</i>					
EXAMINER'S NAME (TYPE OR PRINT)			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/16/86			23c. NAME OF CEMETERY OR CREMATORIAL Baker Cemetery			23d. LOCATION CITY OR TOWN Aberdeen, Harford, Maryland			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR SEP 17 1986						25b. REGISTRAR'S SIGNATURE <i>John T. Tarring</i>						
BP															
DHMH - 17 (VR A15 ME (5))															

10001-00

10001-00

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

26351

REG. NO.

00-18987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ITEM 1&B, AND 3 TO THE MEDICAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3, RETAIN COPIES FOR YOUR FILE. 9 TO FUNERAL DIRECTOR PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS. 8 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF INFECTIOUS DISEASES, 10 17TH STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR	
JOSEPH		W.	BERRY		<input checked="" type="checkbox"/>	9	19	86		
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
MALE	BLACK	JUNE 23, 1932	54 yrs.			<input checked="" type="checkbox"/>	9	19	86	6:07 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOVEVILLE, MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County				
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital (DOA)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY ST. MARY'S	13c. CITY OR TOWN LOVEVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT 5 PARSONS MILL RD.	20656			
14. FATHER'S NAME FIRST JOSEPH		MIDDLE WALKER	LAST BERRY, SR.	15. MOTHER'S MAIDEN NAME FIRST LINA		MIDDLE P.	LAST SOMERVILLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT PAUL BERRY, RT. 1, B 97, LEX. PK., MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) _____ Blunt chest injuries Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. _____ (b) _____ Due to, or as a consequence of (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9-19- 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/truck collision.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Old Rt. 5 so. of 4 Corner Rd., St. Mary's, MD		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										
ACTUAL SIGNATURE		DATE SIGNED 9-20-86								
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/24/86		23c. NAME OF CEMETERY OR CREMATORIAL QUEEN OF PEACE CEM.		23d. LOCATION CITY OR TOWN HELEN, ST. MARY'S		STATE MD.		
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		25a. DATE REC'D. BY REGISTRAR ADDRESS SEP 24 1986 25b. REGISTRAR'S SIGNATURE								

16001-00



retained by the hospital or attending physician.

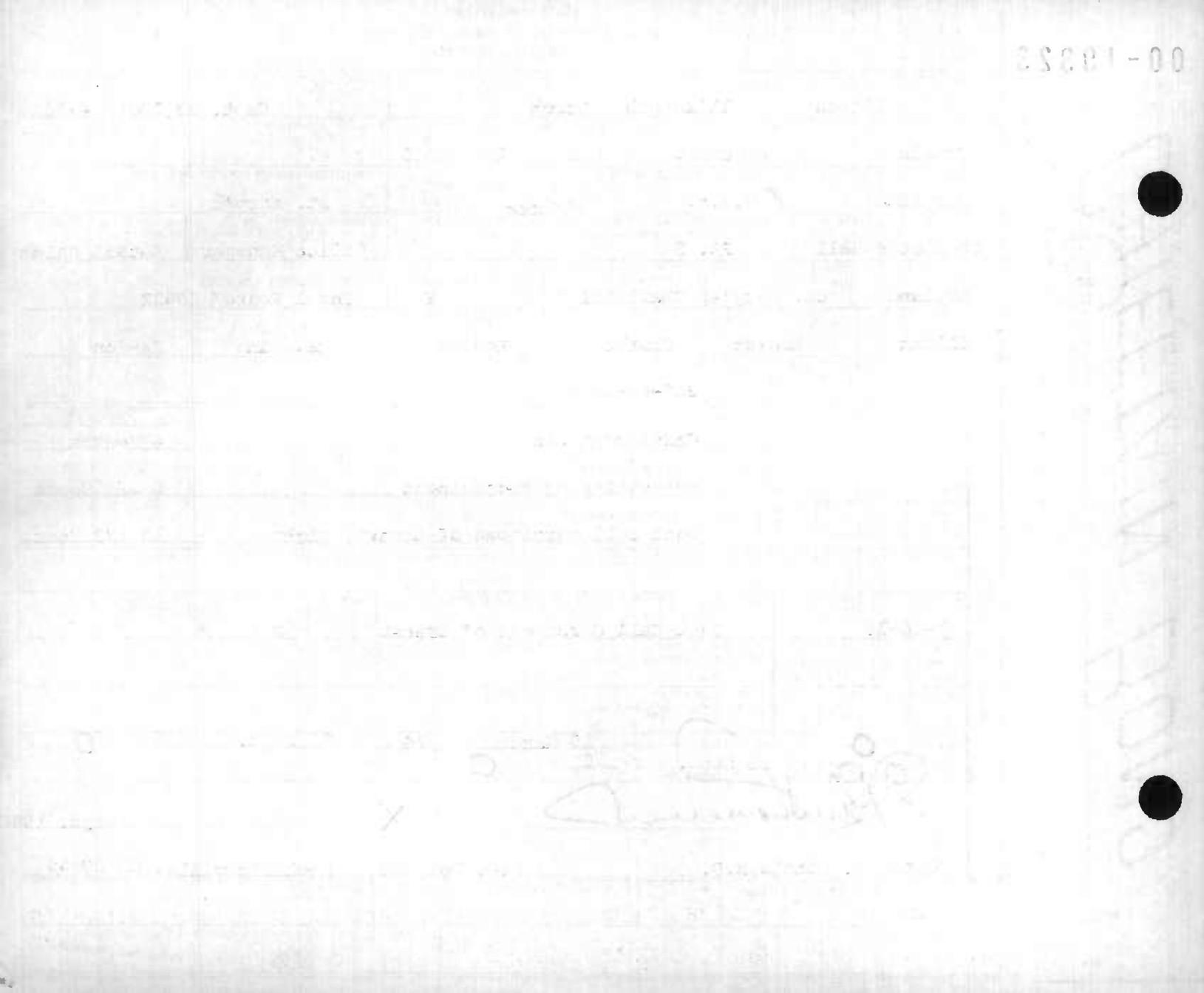
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully, it may be retained by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8626858			
										REG. NO.			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR			
1c DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Sept. 23, 1986 4:38 AM							
Eileen Elizabeth Burch													
1d SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS (LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Caucasian		1 19 1919			67 yrs.		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.A.					St. Mary's						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Charlotte Hall		Rt. 5							Office Manager		Retail Sales		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		St. Mary's		Charlotte H					Rural Route/ 20622				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
William		Ernest		Clarke			Louise		Madeline		Hayden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO				220-09-2809					6 Months				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis													
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma 5 1/2 Years													
DUE TO, OR AS A CONSEQUENCE OF (c) Duct cell carcinoma of breast, right 12 1/2 Years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 3-26-74		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Duct Cell Carcinoma of Breast							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 18 March 1974 to 23 Sept. 1986 , that (I) (we) last saw the deceased alive on 20 Sept. 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased died in hospital, did not view the body after death.)													
22b. SIGNATURE <i>John W. Roache</i>		22c. DEGREE			22d. DATE SIGNED 23 Sept. 1986								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Roache, M.D.		22e. ADDRESS P.O. Box 186 Mechanicsville, MD 20659											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/26/86		23c. NAME OF CEMETERY OR CREMATORIAL CHARLES MEMORIAL GEN. LEONARDTOWN, ST. MARY'S			23d. LOCATION CITY OR TOWN COUNTY STATE		25a. DATE REC'D. BY REGISTRAR -P 25 1986				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25b. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley, MD.</i>											
DHMH - 16 60M 7/B4 (VRA 15, 4)													

28001-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8626859			
1 - STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2d DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR	
REBECCA BRYAN CHAPMAN								SEPT. 17, 1986						3:03 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 MYS.	
FEMALE			CAUCASIAN			MONTH DAY YEAR			98			MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.						
10. CITY OR TOWN OF DEATH LEONARDTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S NURSING HOME			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY						
13a STATE MARYLAND			13b. COUNTY ST. MARY'S			13c. CITY OR TOWN PARK HALL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT. #5, GENERAL DELIVERY 20667			
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER M. BRYAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE CLAGETT									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 217-52-6415			17. INFORMANT ROBERT F. CHAPMAN			18. ADDRESS RT. #2, BOX 165B HOLLYWOOD, MARYLAND 20636						
18. CAUSE OF DEATH (Enter only one cause per line for Part I, Part II or Part III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> APPROXIMATE PATTERN DEATH DUE TO ONE CAUSE DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Atherosclerosis</i> yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I & II															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.															
22b. SIGNATURE <i>J. Patrick Jarboe MD</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/18/86									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. PATRICK JARBOE, M.D.			22f. ADDRESS MEDICAL ARTS BLDG., LEONARDTOWN, MARYLAND												
23a. BURIAL, CREMATION, REMOVAL SPECIFIED BURIAL			23b. DATE 9/20/86			23c. NAME OF CEMETERY OR CREMATORIAL MOUNT REST			23d. LOCATION CITY OR TOWN LaPLATA, COUNTY CHARLES, STATE MARYLAND						
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.						25a. DATE REC'D. BY REGISTRAR SEP 24 1986			25b. REGISTRAR'S SIGNATURE						

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DATA

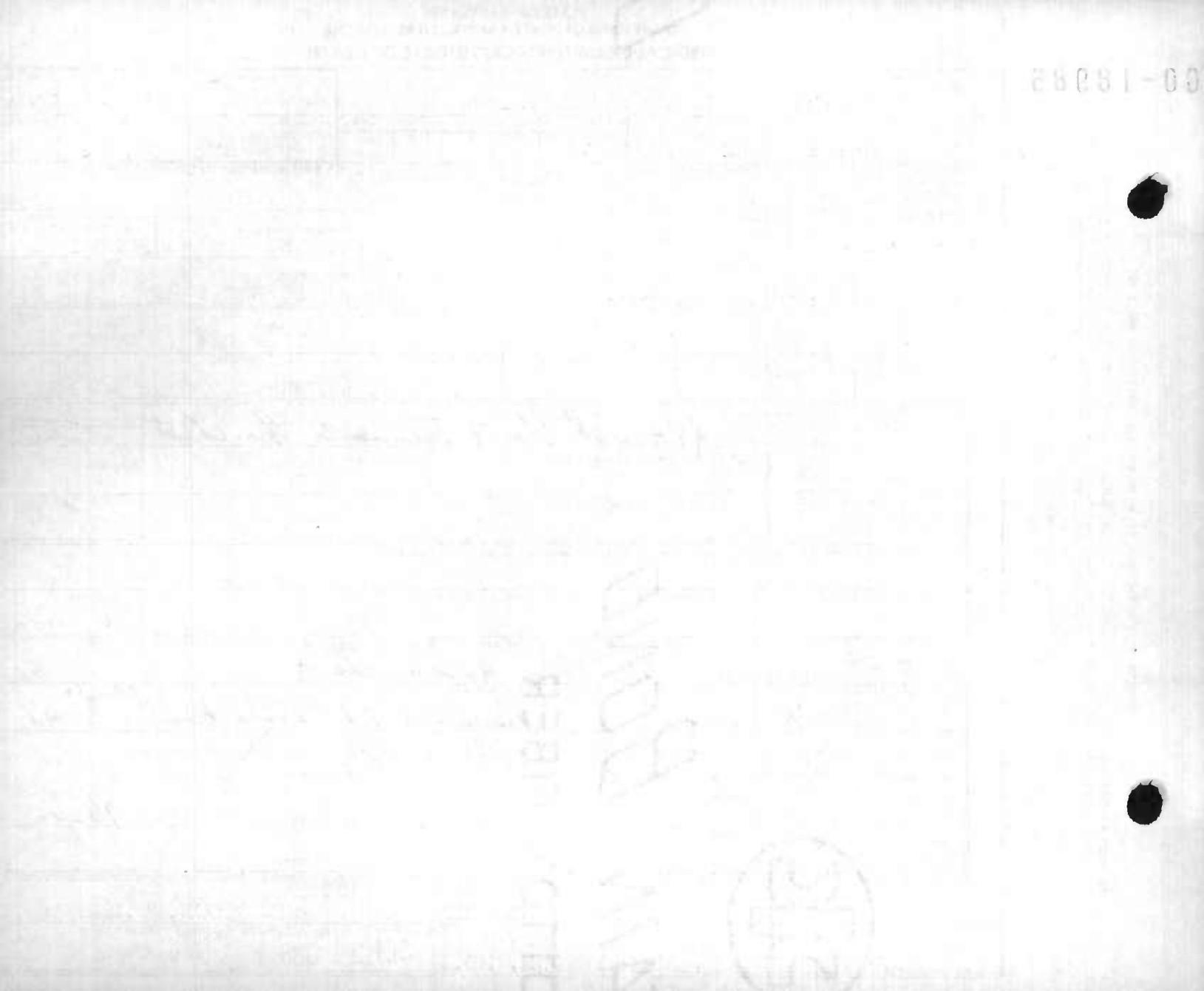


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 26860		
1 - STATE REGISTRAR			2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> SEPT 20 86 0103M											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b HOUR		
TIMOTHY SCOTT CLEMENTS												2d HOUR		
SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR SEPT 20, 1986 0150M			
MALE	WHITE		JUNE 19, 1970		16 yrs.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S					
10. CITY OR TOWN OF DEATH LEONARDTOWN			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT			12b. KIND OF BUSINESS OR INDUSTRY SCHOOL					
13a. STATE MD.		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEONARDTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT 1, BOX 54-A 20650						
14. FATHER'S NAME THOMAS JARROTT CLEMENTS						15. MOTHER'S MAIDEN NAME MARY LILLIAN KNOTT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT THOMAS J. CLEMENTS, SAME AS 13e.			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) <i>MVA with blast trauma to the chest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0103P.M. 9/20 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Auto accident</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Road</i>			21f. LOCATION STREET <i>Fairgrounds Rd, Leonardtown</i> COUNTY <i>St. Mary's Co</i> STATE <i>Md</i>								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY) M.D. _____			MEDICAL EXAMINER			DATE SIGNED 9/22/86					
ACTUAL SIGNATURE <i>JAMES C. BOYD, MD.</i>			EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			TITLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/23/86			23c. NAME OF CEMETERY OR CREMATORIAL CHARLES MEMORIAL GDNS. LEONARDTOWN, ST. MARY'S MD			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 24 1986			25b. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley</i>					
BP _____														
DHMH - 17 (VR A15 ME (5)) 20M 4/82														

26061-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

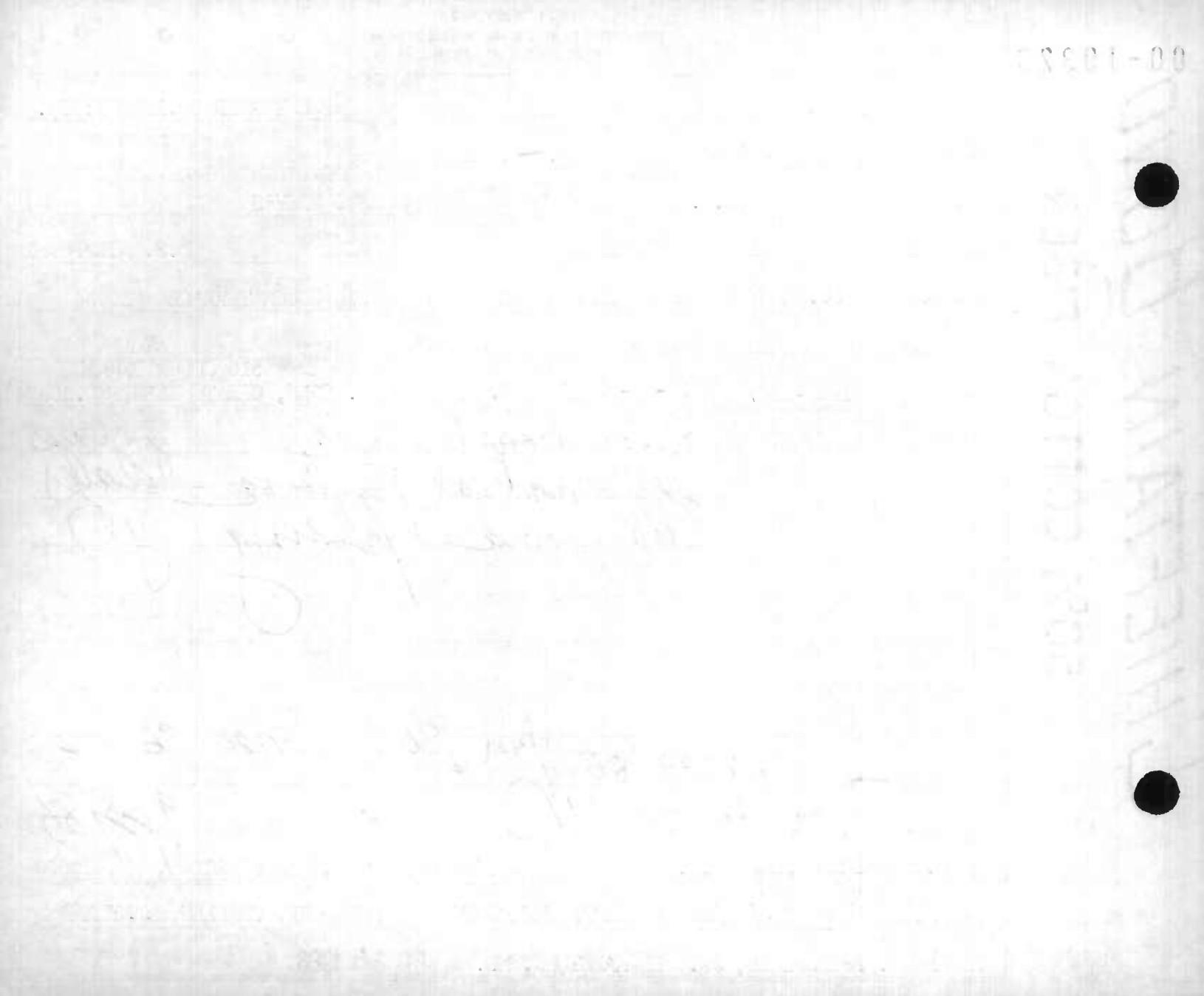
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 & 2 will be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						862686					
						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR				
EUGENE					COLE	SEPTEMBER 20, 1986	7:25p.m.				
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE	DEC. 4, 1917			68	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.				
OHIO		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
GREAT MILLS		516 GOUGH TERRACE			MAJOR		U.S. AIR FORCE				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e. STREET ADDRESS / ZIP CODE					
13b. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN GREAT MILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		516 GOUGH TERRACE 20634			
14. FATHER'S NAME FIRST EDWARD			MIDDLE JAMES	LAST COLE	15. MOTHER'S MAIDEN NAME FIRST SARAH			MIDDLE LAST NICLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) YES			16b. SOCIAL SECURITY NO. 1943-1967			17. INFORMANT MRS. MARGARET B. COLE, GREAT MILLS, MD. 20634			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days					
Respiratory Failure Alveolar Failure Hypoxia of Lung											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 9-20 86 to 9/20 86, that (I) did not see the deceased alive on above, (I) did not view the body after death.											
22b. SIGNATURE <i>J. Patrick Jarboe, M.D.</i>											
22c. AGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME, TITLE OR POSITION J. PATRICK JARBOE, M.D. MEDICAL ARTS BLDG., LEONARDTOWN, MD. 20650											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9/23/86		23c. NAME OF CEMETERY OR CREMATORIAL HUNTT CREMATORY		23d. LOCATION CITY OR TOWN WALDORF, CHARLES, MARYLAND		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE <i>Edward Brinsfield</i>							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 2 6 3 6 2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST CHARLES	MIDDLE CLINTON	LAST DORSEY	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> SEPTEMBER 21, 1986	MONTH SEPTEMBER	DAY 21	YEAR 1986	2b. HOUR 11:30 A.M.	
SEX MALE	RACE WHITE	3. DATE OF BIRTH MONTH APRIL YEAR 1913	4. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	5. IF UNDER 1 YR. MONTHS 0	6. IF UNDER 24 HRS. HOURS 0	MIN. 0	7c. DATE PRONOUNCED DEAD <input type="checkbox"/> SEPT. 21, 1986	MONTH SEPTEMBER	DAY 21	YEAR 1986	2d. HOUR 12:00 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S					
10. CITY OR TOWN OF DEATH PATUXENT RIVER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY CALVERT		13c. CITY OR TOWN LUSBY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS STAR ROUTE 2, BOX 84D 20657			
14. FATHER'S NAME FIRST SEWELL		MIDDLE		LAST DORSEY			15. MOTHER'S MAIDEN NAME FIRST MARGARET		LAST FOWLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS 220-07-9112			17. INFORMANT MRS. BARBARA DORSEY, LUSBY, MARYLAND		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-15 min			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound to Head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>6</u> MONTH <u>9</u> DAY <u>21</u> YEAR <u>1986</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Self inflicted Gunshot wound</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>			21f. LOCATION STREET <u>As Above</u>			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Dal C. K.</u>		TITLE (SPECIFY) M.D. <u>Poppy</u>					MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		DAVID ALLEN, M.D.					ADDRESS LEONARDTOWN, MARYLAND 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-1986			23c. NAME OF CEMETERY OR CREMATORIAL Solomons Methodist			23d. LOCATION CITY OR TOWN Solomons, Calvert, Maryland			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Rt 264, Box 34B, Port Republic, Maryland 20676		ADDRESS Donald V. Borgwardt			25a. DATE REC'D. BY REGISTRAR SEP 29 1986			25b. REGISTRAR'S SIGNATURE <u>Julie Dawson-Poppe</u>				

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10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed by the hospital or attending physician.

11 FUNERAL DIRECTOR. After this certificate has been signed by the attending physician (see completely filled in by the funeral director, page 3) should be affixed to the back of this permit. Then please remove carbon copies (page 1 and 2) should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Died" item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8626863
			REG. NO.		
1. DECEASED NAME <small>(TYPE OR PRINT)</small> GEORGE FRANKLIN FREE			2a. DATE OF DEATH SEPTEMBER 14, 1986	MONTH DAY YEAR	2b. HOUR 10 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH FEB. 12, 1912	6. AGE (IN YEARS LAST BIRTHDAY) 74	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE COUNTRY VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH ABELL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHASKO ROAD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECHANIC	12b. KIND OF BUSINESS OR INDUSTRY Blanken Ford
13. USUAL RESIDENCE (IF NUMBER OF HOMES OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA	13b. COUNTY FAIRFAX	13c. CITY OR TOWN MCLEAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6840 CHELSEA ROAD 22101	999999
14. FATHER'S NAME FIRST GEORGE	MIDDLE W.	LAST FREE	15. MOTHER'S MAIDEN NAME FIRST MARY	MIDDLE ELMIRA	LAST MARCEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) NO	16b. SOCIAL SECURITY NO 225-05-2270	17. INFORMANT MARY FREE, McLEAN, VIRGINIA	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery enterosclerosis; yrs DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DUE TO, OR AS A CONSEQUENCE OF PART 3. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1985</u> , to <u>9/3, 1986</u> that (I) (we) last saw the deceased alive on <u>9/3/86</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE LEON W. BERUBE, M.D.			DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/15/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEON W. BERUBE, M.D.			22e. ADDRESS MECHANICSVILLE, MARYLAND 20659		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 18, '86	23c. NAME OF CEMETERY OR CREMATORIAL Oakwood Cemetery	23d. LOCATION CITY OR TOWN Falls Church	STATE Va.	
24. FUNERAL DIRECTOR NAME Arlington Funeral Home-Arlington, Va.	25a. DATE REC'D. BY REGISTRAR SEP 19 1986			25b. REGISTRAR'S SIGNATURE June L. Berube	

10481-0



- 1 -



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN RACES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26864								
1- STATE REGISTRAR																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN			MIDDLE BARRY			LAST GARZA			2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH 9 MAY 7 1986								
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD MONTH 9 DAY 7 1986		
Male			Caucasian			Apr. 4, 1963			23 yrs.									7d HOUR 10:30 P.M.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X			9. BALTIMORE CITY OR COUNTY OF DEATH											
Cheverly, Md.			US			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			St. Mary's County											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Oakville			Rt. 235			Technician			TV & Satel.											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Charles			Waldorf						Rt. 2, Lot 30 20601								
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME														
FIRST John			Garza			FIRST Barbara			MIDDLE A.			LAST Hooper								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
NO			217-88-1823			John Garza			7035 Evergreen Dr.			Waldorf, Md. 20601								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8152 IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 9:45 P.M. 9-7- 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Operator of motorcycle/fixed object impact.														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 235			CITY OR TOWN Oakville, St. Mary's, MD											
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles P. Kokes, M.D.			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., MD 21201			DATE SIGNED 9-9-86														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9-11-86			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION CITY OR TOWN Waldorf			COUNTY Chas. Md.								
24. FUNERAL DIRECTOR NAME HUNTT FUNERAL HOME			ADDRESS P. O. Box 156 Waldorf, Md. 20601			25a. DATE REC'D. BY REGISTRAR SEP 11 1986			25b. REGISTRAR'S SIGNATURE Julie Leiderer-Baptiste											

63561-80



0-17392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1-7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be noted on the death certificate.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 8 6 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MARGARET			MADGELEN	GOLDSBOROUGH		September 4, 1986				2:40P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Nov. 6, 1944		41		YRS.	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
St. Inigoes, Md		USA				St. Mary's County		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Leonardtown		St. Mary's Hospital									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Valley Lee		Rt. 2, Box 16		20692			
14. FATHER'S NAME FIRST James		MIDDLE A.		LAST Bean		15. MOTHER'S MAIDEN NAME FIRST Isabelle Madglene		MIDDLE Coates		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		ADDRESS					
No		219 48 6471		James A. Bean		Rt. 2, Box 16		Valley Lee, Md. 20692			
18. CAUSE OF DEATH (Enter only one cause per line for part I, II and III.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						ms.					
DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Failure						wk.					
DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic Cirrhosis						ys.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) () attended the deceased from saw the deceased alive on 9/4 1986 and that in my () opinion death occurred on the date and hour and from the causes stated above, (I) () did not view the body after death.											
22b. SIGNATURE <i>J. Patrick Jarboe, M.D.</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		21g. DATE SIGNED 9/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Leonardtown, Maryland 20650							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		9/6/1986		St George Catholic		Valley Lee, St. Mary's, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley		Leonardtown, Maryland									

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CONFIDENTIAL - 1968

Indicates a point of information

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working

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0700 hours, 1968

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24-HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26865					
1- STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR	
WALTER			BENJAMIN			GOODE, JR.						<input checked="" type="checkbox"/>					
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS					2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR		
MALE	WHITE	JAN. 25, 1920	66 yrs.	MONTHS	DAYS	HOURS	MIN				9-16-86	19			M		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED		WIDOWED		DIVORCED		9 BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.			<input type="checkbox"/>			<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		St. Mary's County MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bushwood			Rt. 520 Box 70A									SALESMAN			AUTO PARTS		
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S			13c. CITY OR TOWN BUSHWOOD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RT. #520, BOX 70A 20618					
14. FATHER'S NAME WALTER			MIDDLE B.			LAST GOODE, SR.			15. MOTHER'S MAIDEN NAME MARY			JANE HILL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. W.W.II, KOREAN			17. INFORMANT 213-16-2718			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding gastric ulcer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			4210 MORNINGWOOD DRIVE OLNEY, MARYLAND 20832			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY)					
ACTUAL SIGNATURE Margarita A. Korell, M.D.			M.D. Assistant MEDICAL EXAMINER									DATE SIGNED 9-17-86					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn Street														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/19/86			23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN			23d. LOCATION CITY OR TOWN BRENTWOOD, PRINCE GEORGE, MD.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.			25a. DATE REC'D. BY REGISTRAR SEP 24 1986									25b. REGISTRAR'S SIGNATURE					
DHMH - 17 (VR A15 ME (5))																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 above any injury, or other traumatic event, the medical examiner may be

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 26 867								
										REG. NO.								
1 - FOR STATE REGISTRAR			I. DECEASED NAME			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			LLOYD GRAVES						September 25, 1986			7:00 A.M.						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
MALE		BLACK		MONTH DAY YEAR			83 YRS			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
VA.		USA		SEPT 28, 1902			St. Mary's County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Leonardtown,		St. Mary's Hospital		SUPERVISOR			CONCRETE PLASTERER											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										NT								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE										
MD.		ST. MARY'S		LEXINGTON PARK		NO <input checked="" type="checkbox"/>		RT. BOX 251 (20653)										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
FIRST JOHNNY			LAST GRAVES			113-09-2074			ESTER L. SMITH			RT. 3, BOX 240			LEXINGTON PARK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Colonary artery Disease								
DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF: (c) Chronic Obstructive Pulmonary Disease																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Degenerative arthritis.																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 9/19/86, 1986, to 9/21, 1986, that (I) (we) last saw the deceased alive on 9/24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE A. Patil, M.D.										DEGREE								
22c. PHYSICIAN'S NAME (TYPE OR PRINT) A. Patil, M.D.										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ZION METHODIST CEM			23d. LOCATION CITY OR TOWN LEXINGTON PARK, ST. MARY'S		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.										25a. DATE REC'D. BY REGISTRAR OCT 01 1986			25b. REGISTRAR'S SIGNATURE					
DHMH 16 60M 7/84 (VRA 15, 4)																		

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जिसकी विवरणीयता

के बारे में कहा जाता है।

प्रदेश लोकवाचन विवरणीयता

के बारे में कहा जाता है।

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3	6	2	6	8	6	8
										REG. NO. 00-18313						
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			ROBERT WOODFORD HALL						September 12, 1986						1:12A M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE			WHITE			MONTH DAY YEAR			89			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
MD.			USA						St. Mary's County MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown			St. Mary's Hospital						MAIL CLERK U.S. POSTAL SERV.			20609				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										STAR RT. BOX 56A						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD.			ST. MARY'S			AVENUE										
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						JACKSON				
UNKNOWN																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			213-44-3434			A MARY THELMA HALL			SAME AS 13e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)																
{ DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Organic brain syndrome																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (his hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										Leonardtown, Maryland 20650						
Nayan Shah, M. D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
BURIAL			9/15/86			SACRED HEART CEM.			BUSHWOOD, ST. MARY'S			MD				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.						SEP 17 1986										
DHMH - 16 60M 7/84 (VRA 15, 4)																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

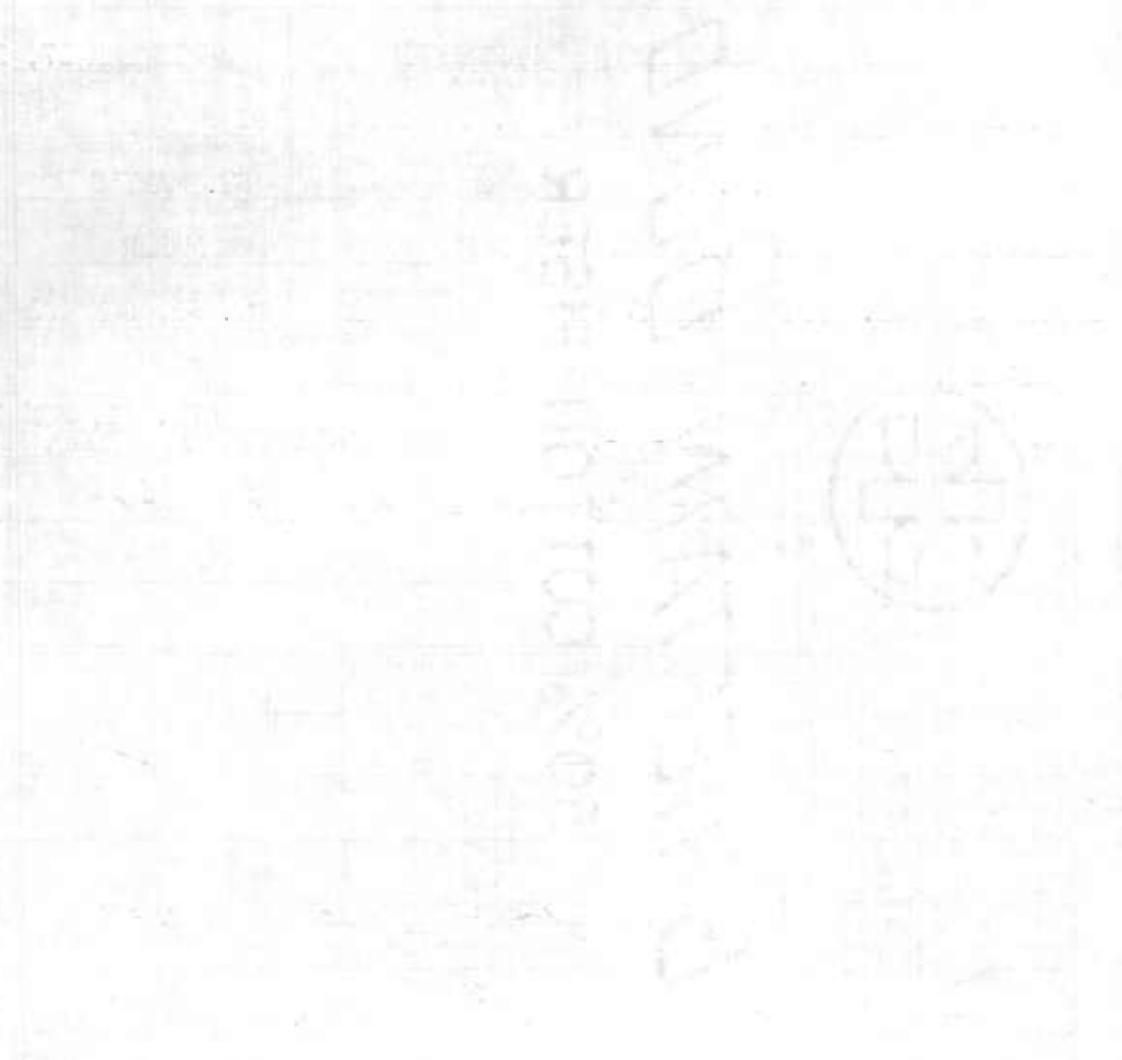
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician should be dispatched for use on the funeral director's permit. Then please remove carbon papers. Please send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" and there is any injury, an other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						86	26	86	9		
						REG. NO.					
1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		ESSIE McCUTCHEOM HARTSHORN					SEPTEMBER 27, 1986				9:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		MONTH DAY YEAR SEPT. 22, 1894		92		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S		MD.			
10. CITY OR TOWN OF DEATH LEXINGTON PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMBER HOUSE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN HOLLYWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. #1, BOX 403		20636	
14. FATHER'S NAME WILLIAM		MIDDLE O.		LAST McCUTCHEOM		15. MOTHER'S MAIDEN NAME ANNIE		LAST		STRUBLE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-48-7456		17. INFORMANT ROBERT HARTSHORN, HOLLYWOOD, MD. 20636		ADDRESS RT. #1, BOX 403					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>					
Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any, if any (b) _____ Due to, or as a consequence of (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>18/12/86</i> , 19 <i>86</i> , to <i>27/12/86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>19/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.)											
22b. SIGNATURE <i>Dad</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/29/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID ALLEN, M.D.		22e. ADDRESS MEDICAL ARTS BLDG., LEONARDTOWN, MD. 20650									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9/29/86		23c. NAME OF CEMETERY OR CREMATORIAL HUNT CREMATORIAL		23d. LOCATION CITY OR TOWN WALDORF, CHARLES, MARYLAND					
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE <i>John Miller</i>					
DHMH - 16 60M 7-B4 (VRA 15, 4)											

57681-00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												6	2	6	8	1	0
												REG. NO.					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR 08:20 4 M			
Carl			Henry			Harvey SR.			9 16 1986								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR 12:10 P.M.			
m		W		01 25 88		78 yrs.						9 16 1986					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		10. BALTIMORE CITY OR COUNTY OF DEATH Charles St. Mary's MD.											
Wash. D.C.		US															
10. CITY OR TOWN OF DEATH Charlotte Hall		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 77		12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction											
13a. STATE MD		13b. COUNTY Charles		13c. CITY OR TOWN Charlotte Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 77-20622									
14. FATHER'S NAME Thomas		MIDDLE Lawrence		LAST Fidler		15. MOTHER'S MAIDEN NAME Ella		16. ADDRESS Rossa Fowler									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-48-2104		17. INFORMANT Dorothy Harvey - same as 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.																	
{ (b) Shotgun Wound of the Abdomen																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 08:20 P.M. 9 16 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Self-inflicted Shotgun Wound of Abdomen													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET Rt 1 Box 77 Charlotte Hall CITY OR TOWN Charles COUNTY MD STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE David N. Gingrich		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 9/16/86											
EXAMINER'S NAME (TYPE OR PRINT) DAVID N. GINGRICH		ADDRESS 5019 Woodhaven Dr. La Plata, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-19-86		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION CITY OR TOWN Suitland		COUNTY Pr. Geo.		STATE Md.							
24. FUNERAL DIRECTOR Huntt Funeral Home		ADDRESS P. O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE John Huntt											
BP _____																	
DHMH - 17 (VR A15 ME (5))																	
20M 4/82																	

0-19551



REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST					2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9/8/86 M		
3. SEX 4 RACE 5. DATE OF BIRTH 6. AGE (IN YEARS MONTH DAY YEAR LAST BIRTHDAY) FEMALE BLACK AUG. 4 1912 74 YRS.					7. IF UNDER 1 YR. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD 9/10/86 P M	
7b. CITIZEN OF WHAT COUNTRY? MD USA					MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County, MD.	
10. CITY OR TOWN OF DEATH REDGATE					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 5, Red Gate	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. STATE MD 13b. COUNTY ST. MARY'S 13c. CITY OR TOWN LEONARDTOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS RT. 5, GEN DEL. (20650)	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY JORDAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VENIA MUGG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 220-28-7295	17. INFORMANT ROSE LEE COOK, WASHINGTON, D.C.	ADDRESS 830 51ST N.E.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio. Dis. Complicated - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					by immersion in water APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> PRIMARY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 97 87 19 86	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell in well	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) residence	21f. LOCATION STREET RT. 5 Red Gate, St. Mary's County, Md.	CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE					TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.					DATE SIGNED 9/11/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 9/15/86	23c. NAME OF CEMETERY OR CREMATORIUM OUR LADY'S CEMETERY	23d. LOCATION CITY OR TOWN MEDLEY'S NECK ST. MARY'S MD.
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.					25a. DATE REC'D. BY REGISTRAR SEP 15 1986 25b. REGISTRAR'S SIGNATURE		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGE 1-2 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 35 RETAIN COPIE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84

BP 288

DHMH - 17
(VR A15 ME (5))

JACV - 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, hand it in to the funeral director. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death. This certificate is valid for 1 year from the date of issue. If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	26	872			
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
ROBERT W. LEE						September 22, 1986			9:00 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		Caucasian		SEPT 17, 1913			73 YRS								
7. BIRTHPLACE (COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. DATE OF BIRTH MONTH DAY YEAR			10. AGE (IN YEARS LAST BIRTHDAY)			11. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
Ohio		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			73 YRS								
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY					
Leonardtown		St. Mary's Hospital		YES <input checked="" type="checkbox"/>			Sub-Station Oper.			PEPCO					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										21037					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE									
Maryland		Anne Arundel		Edgewater		3442 South River Terrace									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			LAST						
UNKNOWN						UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES		WW II		577-09-3816			Hugh M. Maddox			3442 South River Terrace Edgewater, Maryland 21037			Hours		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Weeks					
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF (c) Possible (R) Lung Cancer															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 8/21/86 to 8/22/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.										22b. DATE SIGNED 7/2/86					
22c. SIGNATURE 		22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D.		22e. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE SEPT 25, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem.			23d. LOCATION CITY OR TOWN Cheltenham, Pr. George's, MD								
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Road		25a. DATE REC'D. BY REGISTRAR Sep 29 1986			25b. REGISTRAR'S SIGNATURE 								
DHMH - 16 60M 7/84 (VRA 15, 4)															

50281-00

00-19321

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 8 7 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR
			MAZIE	MARILLA	MILLER	SEPT. 19, 1986				3:08a.m.
3. SEX			4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE			CAUCASIAN	MONTH	DAY	YEAR	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
PENNSYLVANIA			U.S.A.				ST. MARY'S MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
LEONARDTOWN			ST. MARY'S NURSING HOME						12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S	13c. CITY OR TOWN MECHANICSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. #2, BOX 267A 20659			
14. FATHER'S NAME FIRST RUSSELL			MIDDLE L.	LAST McDONALD	15. MOTHER'S MAIDEN NAME FIRST MARGARET		MIDDLE		LAST CHILCOTE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES, NO OR UNKNOWN			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) 224-36-3953		17. INFORMANT RT. #2, BOX 267A NANCY M. LIPKEY, MECHANICSVILLE, MD. 20659					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Severe ASCVD										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19, 1986</u> , to <u>Sept. 19, 1986</u> , thur (if we) last saw the deceased alive on <u>Sept. 19, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>L. Berube M.D.</u>			22c. DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/20/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) LEON W. BERUBE, M.D.			22f. ADDRESS MECHANICSVILLE, MARYLAND 20659							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/22/86		23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERANS		23d. LOCATION CITY OR TOWN CHELTENHAM, PRINCE GEORGE, MD.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.			ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE			

18831-00

(A)

00-19220

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3A. FORM 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 6 2 6 8 1 4
1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN X OF ESTI. DEATH MATED				MONTH DAY YEAR	2b HOUR		
JOSEPH		CHRISTOPHER	MUSCATO		SEPT. 19, 86				3:52a			
3 SEX MALE		4. RACE CAUCAS.		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 17, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 34 yrs.		7f. IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		2c. DATE PRONOUNCED DEAD SEPT. 19, 1986		MONTH DAY YEAR 10:00		
9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S		10. CITY OR TOWN OF DEATH ST. GEORGE ISLAND										
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION RT. #249												
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT SEAMAN												
12b. KIND OF BUSINESS OR INDUSTRY 99999 32211												
13a. STATE FLORIDA												
13b. COUNTY DUVAL		13c. CITY OR TOWN JACKSONVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1431 BELL MEADE BLVD.						
14. FATHER'S NAME JOSEPH		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME MYRTICE		LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 265-17-5867		17. INFORMANT MRS. MYRTICE MUSCATO, JACKSONVILLE, FLA.		ADDRESS 1431 BELL MEADE BLVD., JACKSONVILLE, FLA.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE TRAUMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>related to Motor Vehicle Accident</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 3:52P.M. 9/19 1986		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) AUTO ACCIDENT - PASSENGER								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, ETC.) STREET		21f. LOCATION RT. #249 ST. GEORGE ISLAND, ST. MARY'S, MD.								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural death <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion								
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY)		M.D. MEDICAL EXAMINER								
JAMES C. BOYD, M.D.		ADDRESS		17 JEFFERSON ST., LEONARDTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/23/86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON MEMORIAL								
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		23d. LOCATION CITY OR TOWN JACKSONVILLE, DUVAL, FLORIDA		25a. DATE REC'D. BY REGISTRAR SEP 25 1986								
				25b. REGISTRAR'S SIGNATURE <i>R. Pendleton</i>								

05581-00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

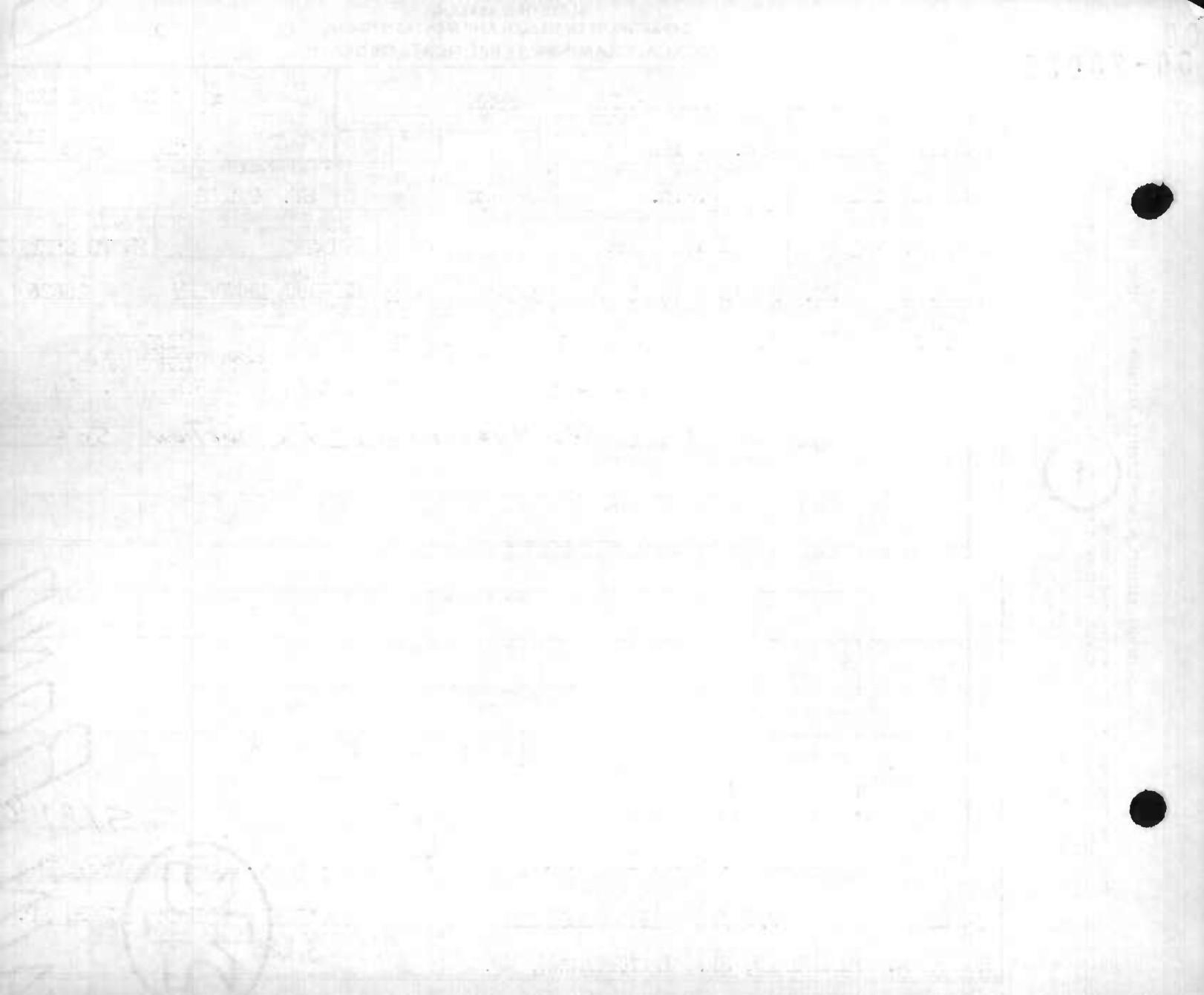
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 2 6 8 7 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
			MINNIE	MARGUERITE	MUSSER	<input checked="" type="checkbox"/>	9/26	19	86	1230 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
FEMALE	WHITE	AUG. 4, 1920	66 yrs.	MONTHS	DAYS	HOURS	MIN			1100 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		NEVER MARRIED	WIDOWED	DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
WEST VIRGINIA		U.S.A.			<input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	ST. MARY'S
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
COLTON'S POINT		BAY VIEW ROAD			PRINTER			PHOTO SERVICE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		MD.			
MARYLAND	ST. MARY'S	COLTON'S POINT	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		GENERAL DELIVERY		20626			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	RUTHERFORD			
WILLARD	W.	BALLINGER	MINNIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1624 BISHOP ROAD				
NO		577-34-8274		CHARLOTTE GLANTON,		EDGEWATER, MD. 21037				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable myocardial infarction.</i> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sec</i>
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> first.										
(b) _____ DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Wm. Boyd Jr.</i>		M.D.		TITLE (SPECIFY) <i>DPT</i>			MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		17 JEFFERSON ST., LEONARDTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
BURIAL		9/30/86		FORT LINCOLN			BRENTWOOD, PRINCE GEORGE, MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				OCT 03 1986						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the Burial transit permit. Then please remove carbon insert. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be out and at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8626876							
										REG. NO.							
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	September 26, 1986							6:10PM				
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
Male			White		August 26, 1970		76			YRS			MONTHS DAYS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			St. Mary's County MD.							
New York City			U. S. A.														
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY										
Leonardtown			St. Mary's Hospital		Clerk		U.S. Gov't										
13. STATE			13. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			21174							
Maryland			Anne Arundel		Crafton		1666 Wilshire Drive										
14. FATHER'S NAME FIRST			MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					(Unascertainable)							
Isaac					Jane												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. ADDRESS										
Yes			WW 2		064-05-9341		Ronald Miller			1503 Pittsfield Lane, Bowie, Maryland 20716							
19. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 9/26/1986 to 9/26/1986, that (I) (we) last saw the deceased alive on 9/26/1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>John D. Boyle</i>										DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>9/27/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <i>John D. Boyle</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY STATE							
Burial			9/30/1986		Maryland Veteran's			Cheltenham		Maryland							
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.										25a. DATE REC'D. BY REGISTRAR <i>OCTO 1 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Lindner</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)																	

0-18767

50715 0001 33 undated

Incident Report - 2000

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 2 is marked by hand, it shows any injury, or other tragicomic event, the medical certificate must be signed by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	2	6	8	7	1			
										REG. NO.									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		7a. DATE OF DEATH		MONTH	DAY	YEAR	7b. HOUR			
		ELOISE NANCY PICKRELL									SEPT. 16, 1986					1325 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE: (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. AGE: (IN MONTHS LAST BIRTHDAY)		9. UNDER 14 DAYS		10. MONTHS		11. DAYS		12. HOURS	
FEMALE		CAUCASIAN		MONTH DAY YEAR OCT. 21, 1911		74		YRS.		74		MONTHS		DAYS		HOURS		MIN.	
7c. BIRTHPLACE (COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8. MARRIED: <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED: <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY							
NEBRASKA		U.S.A.						ST. MARY'S		LIBRARIAN									
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		16. STREET ADDRESS / ZIP CODE											
LEONARDTOWN		ST. MARY'S HOSPITAL		13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEONARDTOWN		P.O. BOX 168		20650							
17. FATHER'S NAME FIRST		MIDDLE		LAST		18. MOTHER'S MAIDEN NAME		19. ADDRESSES											
RAYMOND		D.		PICKRELL		FLORENCE		2006 MIRFIELD LANE											
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		21. SOCIAL SECURITY NO.		22. INFORMANT		23. WAS DECEASED CAUSED BY: IMMEDIATE CAUSE (a)		24. ADDRESSES											
NO		556-14-6218		MRS. JESSE DAUGHERTY,		Cardio pulmonary failure minutes		LEXINGTON PARK, MD.											
25. CAUSE OF DEATH: (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY:		26. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		27. DUE TO, OR AS A CONSEQUENCE OF 28. DUE TO, OR AS A CONSEQUENCE OF		29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
(b)		Ventricular Fibrillation minutes		(c)		Acute Myocardial Infarction minutes													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
30. MEDICAL CERTIFICATION		31a. DATE OF OPERATION		31b. CONDITION FOR WHICH OPERATION WAS PERFORMED		31c. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		31d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
		32a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING: <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		32b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 31, PART 1 OR PART 2)													
		33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
		36. I certify that (if this hospital) attended the deceased from 19 70 to 19 70, that (if I am listed above, (I) did not attend the deceased from 19 86 to 19 86, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) did not see the body before death.		37. SIGNATURE J. PATRICK JARBOE, M.D.		38. DEGREE		39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		40. DATE SIGNED 9/18/86									
		41. PHYSICIAN'S NAME (IF REPORTER)		42. ADDRESS		43. MEDICAL ARTS BLDG., LEONARDTOWN, MD. 20650													
BP		44. BURIAL, CREMATION, REMOVAL BURIAL		45. DATE 9/19/86		46. NAME OF CEMETERY OR CREMATORIUM ST. ANDREWS		47. LOCATION CITY OR TOWN CALIFORNIA, ST. MARY'S, MD.											
		48. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		49. ADDRESS		50. DATE REC'D. BY REGISTRAR SEP 24 1986		51. REGISTRAR'S SIGNATURE											

00001-



00-19322

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 2 6 3 / 8

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMULUM 3. MAIL PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST RALPH	MIDDLE L.	LAST RIDGELL	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 9	DAY 19	YEAR 1986	2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH FEB.	DAY 3,	YEAR 1952	6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0
7a. BIRTHPLACE STATE OR FORIGN COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 9 19 86		2d. HOUR 10A M	
10. CITY OR TOWN OF DEATH St. George's Island		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 249		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
13a. STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN LEXINGTON PK.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 3	20653			
14. FATHER'S NAME FIRST ERNEST		MIDDLE F.	LAST RIDGELL	15. MOTHER'S MAIDEN NAME FIRST MELBA		MIDDLE	LAST DEBUSK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR NUMBER) 1969-1972		17. INFORMANT MARGARET L. RIDGELL, Lexington Park, MD.		ADDRESS P.O. BOX 3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/50 IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:50AM 9-19- 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of pick-up truck/fixed object impact.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Rt. 249, St. George's Island, St. Mary's, MD		CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u>									
23a. EXAMINER'S NAME (TYPE OR PRINT)		23b. DATE SPECIFY BURIAL		23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S		23d. LOCATION CITY OR TOWN RIDGE, ST. MARY'S, MARYLAND		DATE SIGNED 9-20-86	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR SPECIFY SEP 25 1986		25b. REGISTRAR'S SIGNATURE			
BP		DHMH - 17 (VR A15 ME (5))							

33301-00

DIVISION OF VITAL RECORDS 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM E, GIVES PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH A PM 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH AT THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS 251 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26879

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		2b. MONTH DAY YEAR					
IDELL		SIMPSON		<input checked="" type="checkbox"/>		Sept. 14, 1986					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. MONTH DAY YEAR			
FEMALE	BLACK	DEC. 31, 1915	70 yrs.			SEPT. 14, 1986		0800			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
SOUTH CAROLINA		U.S.A.				ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
LEONARDTOWN		ST. MARY'S HOSPITAL				COOK		999999			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MICHIGAN		13b. COUNTY WAYNE		13c. CITY OR TOWN DETROIT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5327 MONTCLAIR ST. 48213	
14. FATHER'S NAME FIRST MIDDLE LAST		WILL BARNEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		BERTHA COLLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		264-03-9988		VANESSA G. BALDWIN, DETROIT, MICHIGAN		sec.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Portable STROKE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>William D. Boyd, Jr.</u>											
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		S/18/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
BURIAL		9/20/86		CHARLES MEMORIAL GARD.		LEONARDTOWN, ST. MARY'S, MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				SER 4 1986							

6601-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within one hour after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified filed in by the funeral director, page 3 should be detached from the Bureau Health and Mental Hygiene prior to burial (cremation), or removal with the State Dept. of Health and Mental Hygiene prior to burial (cremation). If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical certifier must be contacted before the certificate is filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	2	6	8	0	
										REG. NO.						
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			MARGARET SHANER SMITH						September 2, 1986						4:40 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			CAUCASIAN			MONTH DAY YEAR DEC. 2, 1898			87			MONTHS		DAYS		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
VIRGINIA			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			St. Mary's County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown			St. Mary's Hospital			SECRETARY			CIVIL SERVICE							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
FLORIDA			LEE			LEHIGH						1003 ROOSEVELT AVE. 33936				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
			WALTER	PHILLIP	SHANER				MARY	ANN	DEDAKER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			226-03-6531			NICHOLAS J. SMITH, III, HOLLYWOOD, MD. 20636			P.O. BOX 22							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Cerebrovascular Accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that in (this hospital) attended the deceased from 8/2/86 to 9/2/86 , and that in my (or) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.)																
22b. SIGNATURE <i>David C. Allen</i>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/2/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D.										22e. ADDRESS Leonardtown, Md. 20650						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/4/86			23c. NAME OF CEMETERY OR CREMATORIAL PRESBYTERIAN			23d. LOCATION CITY OR TOWN LYNCHBURG, LYNCHBURG, VA.			COUNTY				
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.			ADDRESS						25a. DATE REC'D. BY REGISTRAR SEP. 5 1986			STATE				

00-15200

3000, S. component

0.010,

Kinetic

Velocity of wave

1.6490 ± 0.0000

infrared

Wavelength

Wavenum

0-17950

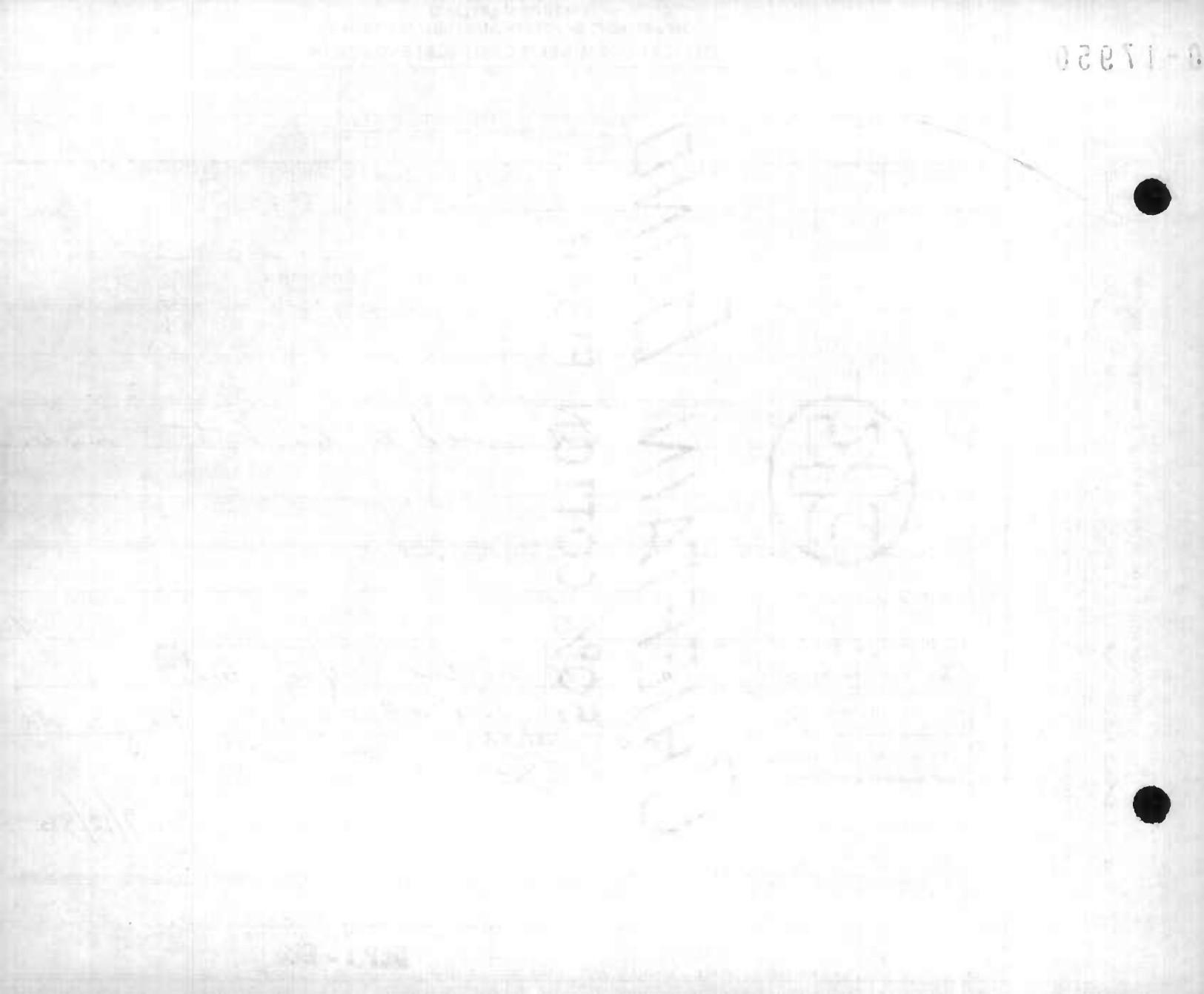
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PIA. RETAIN PAGE 5, RETAIN PAGE 1 AND 2 SHOULD BE FILED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26381				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR				
			ROBERT LEWIS STONE						<input type="checkbox"/> SEPT. 8, 86			M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR		
MALE		WHITE		MAY 7, 1959		27 yrs.						SEPT. 8, 86		M		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.			USA									ST. MARY'S				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
MECHANICSVILLE			HOME			ASST. FORMAN			CONSTRUCTION							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET ADDRESS				
MD.			ST. MARY'S			MECHANICSVILLE						RT. 3, BOX 359 (20659)				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
THOMAS GROVER STONE 11			ALMA LORINE CHATEL													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT										
NO			217-74-4962			KATHY SUE STONE SAME AS 13e.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Gun shot wound to the chest</i>												medic				
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
(b)																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
			1230 P.M. 9/8/ 1986			see above - self inflicted										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION										
			New House - apto			STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held on			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion										
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE			M.D.			TITLE (SPECIFY)										
EXAMINER'S NAME (TYPE OR PRINT)			JAMES C. BOYD, M.D.			MEDICAL EXAMINER										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE				
BURIAL			9/11/86			CHARLES MEMORIAL GDNS. LEONARDTOWN, ST. MARY'S MD										
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.						SEP 15 1986			John D. [Signature]							
07/84 25M																
BP																
DHMH - 17																
(VR A15 ME (5))																

0-15820



00-19932

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 2 6 6 8 2

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ANITA GUYTHER SWANN						SEPTEMBER 28 1986					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MAY 20, 1889		97		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MD.		USA				ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		CE			
LEONARDTOWN		ST. MARY'S NURSING HOME		POSTMISTRESS		US POST OFFICE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		GENERAL DELIVERY (20674)	
MD.		ST. MARY'S		PINEY POINT		YES <input type="checkbox"/>		ADDRESS		GEN. DEL. PINEY POINT, MD.	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	ADAMS			
GEORGE			GUYTHER	LENA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		220-44-8056		MRS. HELENA THOMPSON				WKS.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary Failure</i> DUE TO, OR AS A CONSEQUENCE OF 161. <i>Musculoskeletal Failure</i> DUE TO, OR AS A CONSEQUENCE OF 162. <i>Generalized Arteriosclerosis</i> years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) this physician attended the deceased from <u>1920</u> , 19 <u>60</u> , to <u>9/28</u> , 19 <u>76</u> , that (I) (he) last saw the deceased alive on <u>1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>John Harboe M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/30/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/1/86		23c. NAME OF CEMETERY OR CREMATORIUM ST. GEORGE CEMETERY		23d. LOCATION VALLEY LEE ST. MARY'S MD.		COUNTY		STATE	
BURIAL											
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copies 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or typed, 18 shows any injury, or other traumatic event, the medical examiner may be notified.

SC001-00

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the medical section, page 3 should be detached for use at the burial or funeral service. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If Item 21 is marked or Item 22 is marked or Item 23 is marked or Item 24 is marked or Item 25 is marked

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 8 8 5
0-18722

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR	
			WILLIAM	C.	TRADER	SEPT.	16	16, 1986		M	
12. SEX		14. RACE		15. DATE OF BIRTH		16. AGE (IN YEARS LAST BIRTHDAY)			17. IF UNDER 1 YEAR		
Male		White		July 4, 1902		84 YRS			MONTHS	DAYS	
18. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		19. CITIZEN OF WHAT COUNTRY?		20. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		21. BALTIMORE CITY OR COUNTY OF DEATH			22. IF UNDER 24 HRS		
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ST. MARY'S			MONTHS	HOURS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
LEXINGTON PARK		AMBER HOUSE NURSING HOME		Retired		21801					
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Poplar Hill Avenue			
14. FATHER'S NAME FIRST Byrd		MIDDLE		LAST Trader		15. MOTHER'S MAIDEN NAME FIRST Maggie		MIDDLE		LAST Adkins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
NO		220-01-8532		Mrs. Wm. Trader		Box 490 Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carboenteritis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24.											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1985 to 1986, that (I) (we) last saw the deceased alive on 9/5/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Wm. Boyd Trader</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/17/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, M.D.		22e. ADDRESS LEONARDTOWN, MD. 20650									
23a. BURIAL, CREMATION, REMOVAL (TYPE #) Burial		23b. DATE 9/20/86		23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		23d. LOCATION CITY OR TOWN Salisbury		COUNTY Wicomico		STATE Md.	
24. FUNERAL DIRECTOR NAME James L. Seaman		ADDRESS Princeton Home, Md.		25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE Jane Dawson					

33791-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

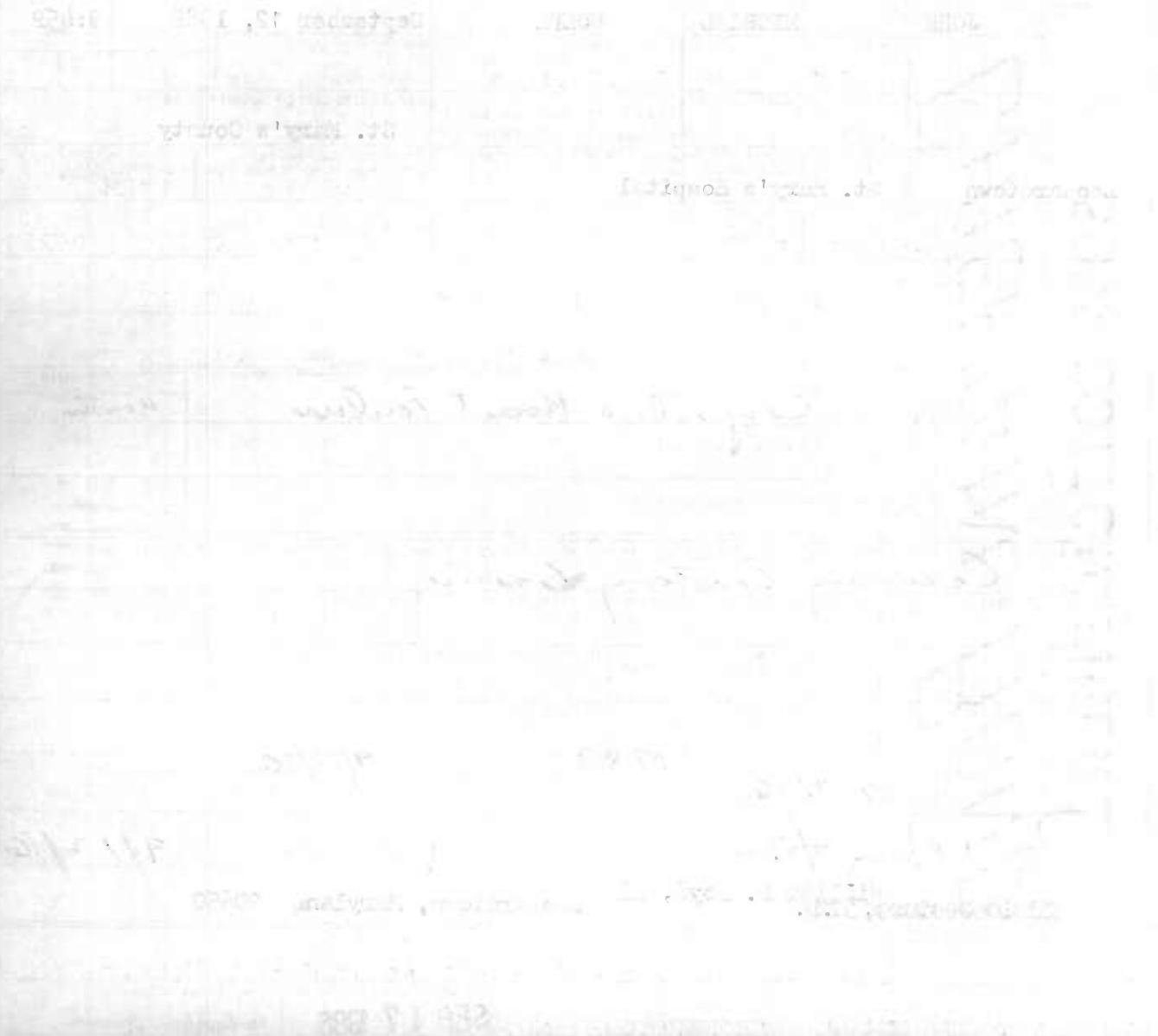
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-disposal permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	2	6	8	8	4		
										REG. NO.								
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	September 12, 1986							9:45P M					
JOHN MICHAEL WOLFE																		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
MALE			WHITE		DEC. 26, 1904			81 YRS.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.						
BALTIMORE, MD.			USA					St. Mary's County										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Leonardtown			St. Mary's Hospital							FARMING				FARM				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE						
MD.			ST. MARY'S		MADDOX							STAR RT. BOX 270 (20621)						
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST									
JOHN				WOLFE	ELIZABETH				GROTHHEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS										
NO					EMMA FRANCES WOLFE, SAME AS 13e.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Congestive Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months.				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)								
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										Coronary artery disease								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
										YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1983, 19, to 7/12/86, 19, that (I) (we) last saw the deceased alive on 9/12/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE										DEGREE	ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED	
William D. Boyd, II											<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		9/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							22f. ADDRESS								
William D. Boyd, II			Leonardtown, Maryland 20650															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				23e. COUNTY STATE						
BURIAL			9/15/86		ST. PAUL'S CEMETERY LEONARDTOWN, ST. MARY'S MD.													
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE								
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.										SEP 17 1986				John Davidson, Registar				
DHMH 16 60M 7/84 (VRA 15, 4)																		

00-18315



00-19324

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR PAGES 1 AND 2. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 20201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6 2 6 8 8 5	
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 9-20 1986							2b. HOUR 0103 M	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2c. DATE ESTI- DEATH MATED <input type="checkbox"/> MONTH DAY YEAR 9-20 1986				2d. HOUR 0145 M	
PATRICK CHRISTOPHER WOLFORD											
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S			
MALE	WHITE	DEC. 23, 1968	17 yrs.					MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S			
11. CITY OR TOWN OF DEATH LEONARDTOWN			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK) (FOR MOST WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN VALLEY LEE				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS STAR ROUTE, BOX 133A 20692			
14. FATHER'S NAME FRED			MIDDLE LEON		LAST WOLFORD, JR.	15. MOTHER'S MAIDEN NAME MARSHA			16. VAUPEL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 340-56-4430			17. INFORMANT MR. FRED L. WOLFORD, JR., VALLEY LEE, MD.			ADDRESS STAR RT. BOX 133A, VALLEY LEE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) <i>Motor Vehicle Accident with multiple trauma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 103 P.M. 9/20 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Auto accident</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Road</i>			21f. LOCATION STREET <i>Fair Ground Rd</i> CITY OR TOWN <i>Leonardtown</i> COUNTY <i>St. Mary Co Md</i> STATE <i></i>					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion					
ACTUAL SIGNATURE <i>J.C. Boyd</i>			TITLE (SPECIFY) M.D. <i></i>			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D.			ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.			DATE SIGNED 9/22/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/24/86			23c. NAME OF CEMETERY OR CREMATORIAL ST. ANDREWS			23d. LOCATION CITY OR TOWN CALIFORNIA, ST. MARY'S, MD.		
24. FUNERAL DIRECTOR NAME <i>EDWARD N. BRINSFIELD, JR.</i> ADDRESS <i>LEONARDTOWN, MD.</i>						25a. DATE REC'D. BY REGISTRAR SEP 26 1986			25b. REGISTRAR'S SIGNATURE <i>Edward N. Brinsfield Jr.</i>		

00-18330

DIVISION OF VITAL RECORDS 201 W PRESTON ST BALTIMORE MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 1 AND 2, WHICH SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

MEDICAL CERTIFICATION

**1 - FOR
STATE
REGISTRAR**

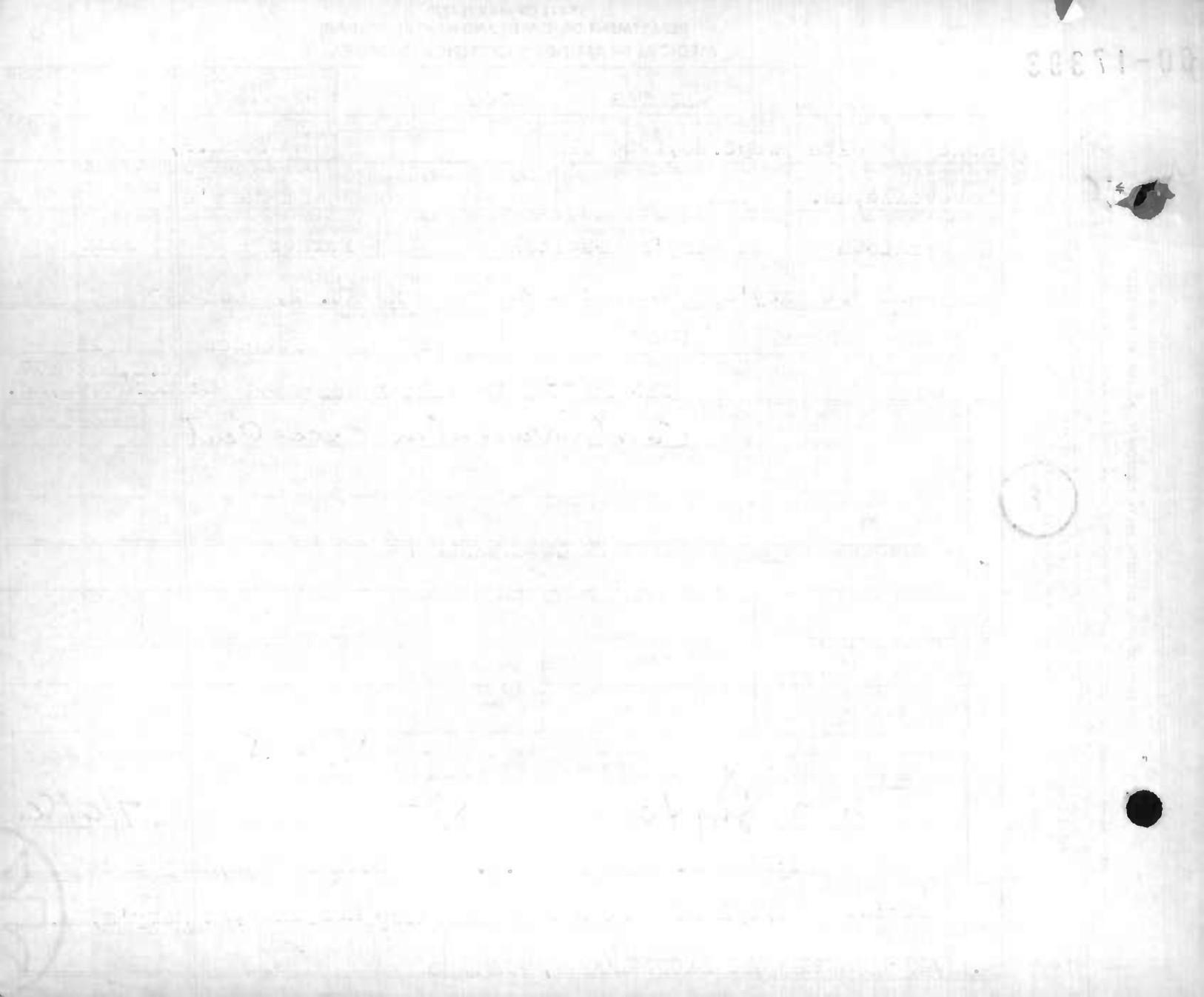
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26385

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR
DANIEL WEBSTER WOOD						<input checked="" type="checkbox"/>			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR
Male	White	Sept. 26, 1904	81 yrs.	MONTHS	DAYS	Hours			
7a BIRTHPLACE (STATE OR COUNTRY) Loveville, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St Mary's			
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. STATE Maryland		13b. COUNTY St Mary's		13c. CITY OR TOWN Leonardtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 177	
14. FATHER'S NAME Henry Edward		MIDDLE Wood		15. MOTHER'S MAIDEN NAME Mary		16. SOCIAL SECURITY NO. 215 36 7353		17. INFORMANT Lucille Agnes Wood	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		17. INFORMANT Lucille Agnes Wood		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>William D. Boyd</u>									
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED		7/6/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/8/1986		23c. NAME OF CEMETERY OR CREMATORIUM St Joseph Cemetery		23d. LOCATION CITY OR TOWN Morganza, St Mary's, Md.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. DATE RECEIVED BY REGISTRAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE			

30051-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "No" it shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	2	6	8	3	1
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
IDA			MARY	WOOD			September 15, 1986						7:30P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
FEMALE		WHITE		MARCH 1, 1906		80			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			St. Mary's County MD.							
MD.		USA														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Leonardtown			ST. MARY'S HOSPITAL							HOUSEWIFE			HOME			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
MD.			ST. MARY'S		LOVEVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		GENERAL DELIVERY (20656)							
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST							
EDGAR			SHERMAN	JONES	ANNIE			M.	ALVERY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
NO			213-50-9285		WILLIAM M. WOOD, JR. HELEN, MD. 20635			GEN. DEL.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Electrical Mechanical dissociation																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
(b) Acute myocardial Infarction										1 hour						
(c) Cerebral Artery disease																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
Prior to 1974 & 1982: Angina pectoris																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from September 15, 1986, to September 15, 1986, that (1) (we) last saw the deceased alive on September 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Edwin E. Westura, M.D.</i>										DEGREE						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
Edwin E. Westura, M.D.										22e. ADDRESS Leonardtown, Md. 20650						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
BURIAL			9/18/86		QUEEN OF PEACE			HELEN		ST. MARY'S		MD.				
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
										SEP 18 1986						

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